

## PERTUSSIS CASE REPORT

### PATIENT DEMOGRAPHICS

Patient name—last	first	middle initial	Date of birth ____/____/____	Age (enter age and check one) ____ <input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Address (number, street)			City	State	ZIP code
County					

**ETHNICITY** (check one)  Hispanic or Latino  Not Hispanic or Latino  Unknown

**RACE** (check all that apply)

<input type="checkbox"/> Unknown	<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander
<input type="checkbox"/> African-American or Black	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Native Hawaiian
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Cambodian	<input type="checkbox"/> Guamanian
<input type="checkbox"/> White	<input type="checkbox"/> Chinese	<input type="checkbox"/> Samoan
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Filipino	<input type="checkbox"/> Other Pacific Islander: _____
	<input type="checkbox"/> Hmong	
	<input type="checkbox"/> Japanese	
	<input type="checkbox"/> Korean	
	<input type="checkbox"/> Laotian	
	<input type="checkbox"/> Thai	
	<input type="checkbox"/> Vietnamese	
	<input type="checkbox"/> Other Asian: _____	

**Occupation** (check all that apply)

Food service  Health care  Day care  School  Correctional facility  Other: \_\_\_\_\_

Country of birth	Country of residence
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### COMMON LHD TRACKING DATA

CMRID number	IZB Case ID number	Web CMR ID number
Date reported to county ____/____/____	Date investigation started ____/____/____	Person/clinician reporting case
		Reporter telephone ( )
Case investigator completing form	Investigator telephone ( )	Investigator's LHD or jurisdiction

### SIGNS AND SYMPTOMS

Cough <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Cough onset date ____/____/____	Paroxysmal cough <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Whoop <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Post-tussive vomit <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Apnea <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Other symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Describe other symptoms		
Final interview date ____/____/____	Cough at final interview <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Cough duration at final interview (in days)	Diagnosis date ____/____/____	
Does case meet clinical criteria for further investigation ? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<b>CASE MEETS CDC/CSTE CLINICAL CRITERIA? (FOR STATE USE ONLY)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		

### COMPLICATIONS AND OTHER SYMPTOMS

Hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Days hospitalized _____	Chest x-ray for pneumonia <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	Intubated <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Days intubated _____
Seizures due to pertussis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Acute encephalopathy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Death <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date of death ____/____/____	
Other complications <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Describe			

### TREATMENT

1. Were antibiotics given ? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Antibiotic 1 code	Date started ____/____/____	Number of days given
2. Were antibiotics given ? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Antibiotic 2 code	Date started ____/____/____	Number of days given

**ABX CODES:**

1 = Erythromycin (includes pediazole)	4 = Tetracycline/doxycycline	7 = None
2 = Cotrimoxazole (bactrim/sepra)	5 = Amoxicillin/Penicillin/Ampicillin/Augmentin/Ceclor	8 = Clarithromycin
3 = Azithromycin	6 = Other	9 = Unknown

### LABORATORY TESTS

Any lab tests done for pertussis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	CASE LAB CONFIRMED (FOR LHD USE) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	CASE LAB CONFIRMED (FOR STATE USE ONLY) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Culture <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Specimen date ____/____/____	Culture result (see codes) <input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> I <input type="checkbox"/> E <input type="checkbox"/> X <input type="checkbox"/> S <input type="checkbox"/> U
PCR performed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	PCR specimen date ____/____/____	PCR result (see codes) <input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> I <input type="checkbox"/> E <input type="checkbox"/> X <input type="checkbox"/> S <input type="checkbox"/> U
Other lab tests performed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Specify other lab tests	Other lab test results

**LAB RESULT CODES**  
 P = Positive  
 N = Negative  
 I = Indeterminate  
 E = Pending  
 X = Not done  
 S = Parapertussis  
 U = Unknown

**VACCINATION/MEDICAL HISTORY**

Received one or more doses of pertussis containing vaccine <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Number of doses prior to illness onset
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Dates of vaccination—Dose 1 ____/____/____	Dose 2 ____/____/____	Dose 3 ____/____/____	Dose 4 ____/____/____	Dose 5 ____/____/____	Dose 6 ____/____/____
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Reason not vaccinated

1 <input type="checkbox"/> Personal Beliefs Exemption (PBE)	4 <input type="checkbox"/> Lab confirmation of previous disease	7 <input type="checkbox"/> Delay in starting series or between doses
2 <input type="checkbox"/> Permanent Medical Exemption (PME)	5 <input type="checkbox"/> MD Diagnosis of previous disease	8 <input type="checkbox"/> Other
3 <input type="checkbox"/> Temporary Medical Exemption	6 <input type="checkbox"/> Under age for vaccination	9 <input type="checkbox"/> Unknown

Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Immunocompromised <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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**EPIDEMIOLOGICAL EXPOSURE HISTORY**

Acquisition setting (check all that apply):

1 <input type="checkbox"/> Day care	4 <input type="checkbox"/> Hospital ward	7 <input type="checkbox"/> Home	10 <input type="checkbox"/> College	13 <input type="checkbox"/> Church
2 <input type="checkbox"/> School	5 <input type="checkbox"/> Hospital ER	8 <input type="checkbox"/> Work	11 <input type="checkbox"/> Military	14 <input type="checkbox"/> International travel
3 <input type="checkbox"/> Doctor's office	6 <input type="checkbox"/> Outpatient hospital clinic	9 <input type="checkbox"/> Unknown	12 <input type="checkbox"/> Correctional Facility	15 <input type="checkbox"/> Other

Close contact with person(s) with cough 21 days before cough onset?  Yes  No  Unknown

#	Name	Cough Onset Date	Relationship	Age (Years)	Same Household
1		____/____/____			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
2		____/____/____			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
3		____/____/____			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Please list other contacts on a separate sheet or use the contact tracing work sheet.

Epi-linked to a lab-confirmed case? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Case name or Case ID	Outbreak related <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Outbreak name or location
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**CONTACT INVESTIGATION**

Spread setting (check all that apply):

1 <input type="checkbox"/> Day care	4 <input type="checkbox"/> Hospital ward	7 <input type="checkbox"/> Home	10 <input type="checkbox"/> College	13 <input type="checkbox"/> Church
2 <input type="checkbox"/> School	5 <input type="checkbox"/> Hospital ER	8 <input type="checkbox"/> Work	11 <input type="checkbox"/> Military	14 <input type="checkbox"/> International travel
3 <input type="checkbox"/> Doctor's office	6 <input type="checkbox"/> Outpatient hospital clinic	9 <input type="checkbox"/> Unknown	12 <input type="checkbox"/> Correctional Facility	15 <input type="checkbox"/> Other

Number of contacts for whom antibiotic was recommended	Number of ill contacts
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<b>CASE CLASSIFICATION (FOR LHD USE)</b> <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect <input type="checkbox"/> Not a case <input type="checkbox"/> Unknown	<b>CASE CLASSIFICATION (FOR STATE USE ONLY)</b> <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect <input type="checkbox"/> Not a case <input type="checkbox"/> Unknown
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**PERTUSSIS CASE CLASSIFICATION**

Clinical Case Definition: A cough illness lasting at least 2 weeks with one of the following: paroxysms of coughing, inspiratory "whoop," or post-tussive vomiting, without other apparent cause (as reported by a health professional)

Laboratory Criteria for Diagnosis

- Isolation of *Bordetella pertussis* from clinical specimen
- Positive polymerase chain reaction (PCR) for *B. pertussis*

Case Classification:

Probable: meets the clinical case definition, is not laboratory confirmed, and is not epidemiologically linked to a laboratory-confirmed case

Confirmed: a case that is culture positive and in which an acute cough illness of any duration is present; or a case that meets the clinical case definition and is confirmed by positive PCR; or a case that meets the clinical case definition and is epidemiologically linked directly to a case confirmed by either culture or PCR.